Date: October 8, 1997 DSL-BQA-97-041

To: Hospices HSPCE 17

From: Judy Fryback, Director
Bureau of Quality Assurance

Information on Conditions of Participation for Hospice Agencies

Attached is information shared between the federal Health Care Financing Administration Central Office in Baltimore and the Chicago Regional Office. This information deals with conditions of participation (CoPs) for hospice agencies receiving Medicare reimbursement. It is intended to clarify common areas of concern in ten areas of hospice operation. In addition, we have attached a legislative updated that discusses Medicare Hospice Benefit Amendments.

Please direct any questions you may have to Richard Cooperrider, Supervisor, Community-Based Provider Program, at (608) 267-7389, or Stephen D. Schlough, P.E., Chief, Health Services Section, at (608) 266-2878.

Attachment

JF/JF/jh

Department of Health & Human Services
Health Care Financing Administration
MEMORANDUM

DATE: June 27, 1997

FROM: Director, Office of Chronic Care and Insurance Policy, BPD
Deputy Director for Survey and Certification, HSQB

SUBJECT: Medicare Hospice Conditions of Participation

TO: All Regional Administrators

Purpose

This memorandum is to address specific topics related to the Medicare hospice conditions of participation (CoPs) in the context of current survey and certification policies. The purpose is to provide RO Staff and surveyors with additional guidance to assist in dealing with common areas of concern discovered in a recent series of surveys. Please share this information with the States in your region.

Background

As a result of various factors, hospice survey activity in the regions has increased. The effect of increased attention to hospice surveys has been to identify some areas of confusion concerning the appropriate interpretation of the federal regulations pertaining to the hospice program.

Some of the concerns identified by recent surveys include – a lack of understanding of pain management and palliative care, failure to provide services, medications and settings appropriate to patient/family needs, lack of coordination of services, non-compliance with the core services requirement at 42 CFR 418.80, and lack of interdisciplinary care planning that assures that the patient's medical, physical, social, emotional and spiritual needs are identified and addressed.

Approach

In the following sections, we address the issues and discuss them. It is our intention that this information will be used to supplement the regulations and interpretive guidelines when hospice surveys are performed. We have developed the material in this memorandum in discussion with the San Francisco Regional Office and the Health Standards and Quality Bureau.

(1) Plan of Care:

Hospices participating in the Medicare program must use an interdisciplinary approach to assessing the medical, physical, social, emotional and spiritual needs of the patient and continue this approach while caring for the patient and family. The regulations at 42 CFR 481.58 require the hospice to have a written plan of care established by the attending physician, the medical director or physician designee and interdisciplinary group (IDG) prior to providing care. The regulations at 42 CFR 481.58 also require that the plan of care be reviewed an updated, at intervals specified in the plan, by the attending physician, the medical director or physician designee and the IDG. We would expect these reviews and updates to be completed in such a way as to ensure that the plan of care continues to reflect the patient's condition and to meet the needs of the patient and his/her family.

The hospice may chose to develop an initial plan of care at admission that is based on the limited information obtained, or the priorities identified, during the initial evaluation and is consistent with the patient/family's immediate care needs and desires. The initial plan of care may be developed by the hospice nurse or physician in consultation with the patient's attending physician, if the patient has an attending physician, and one other member of the IDG. However, the other 2 members of the IDG must review the initial plan of care and provide their input

into the process of establishing the plan of care within two calendar days following the assessment. A meeting of group members is not required within this 2-day period; input may be provided by telephone.

The attending physician, the medical director or physician designee and the IDG are to work actively together to establish the overall plan of care. This plan of care must include an assessment of the individual's needs, identification of the services to be provided including the management of pain and other uncomfortable symptoms and must state in detail the scope and frequency of services needed to meet the patient's and family's needs. A range of services is acceptable as long as it continues to meet the identified needs of the patient/family. The hospice physician and IDG are responsible for establishing a system of communication and integration of services that ensures that the plan of care continues to be reviewed and updated to serve the dying person and his/her family well.

It is not permissible for the attending physician to provide the sole guidance for the plan of care or for the hospice director to do so. The law and regulation require that it be the combined work of the IDG. Where this may not be the case, we would expect the hospice to introduce corrective procedures to ensure the involvement of the whole team as soon as feasible after election.

(2) Professional Management:

The use of the term "professional management" for a hospice patient who resides in a skilled nursing facility or other place of residence should have the same meaning to a hospice that it would have if the hospice patient were living in his/her own home. The professional services usually provided by the hospice to the patient in his/her own home should continue to be provided by the hospice to the resident. This includes furnishing any necessary medical services to those patients that the hospice would normally furnish to patients in their homes. In addition, substantially all hospice core services (physician services, nursing services, medical social services, and counseling) must be routinely provided directly by hospice employees and cannot be delegated. The hospice may involve the residential staff who are permitted by the facility and by law in assisting with the administration of prescribed therapies included in the plan of care only to the extent that the hospice would routinely utilize the services of a hospice patient's family caregiver in implementing the plan of care.

Hospices and home health agencies generally train family members to administer medications for patients in the home; however, most nurse practice acts require that this be done by registered nurses. Accordingly, we believe it is appropriate for a hospice to arrange with nursing facility staff to administer medications as would be done by family members. We do not currently know of any other departure from the strict enforcement of the core services requirement that would be appropriate. The hospice assumes full responsibility for the professional management of the hospice patient's care related to the terminal illness. It is the responsibility of the hospice to ensure that *all* services are provided in accordance with the plan of care at all times and in all settings (e.g., the home, place of residence, outpatient, and inpatient settings.)

(3) Medical Director:

The medical director of the hospice is expected to assume overall responsibility for the medical component of the hospice's patient care program. The medical director, or the physician member of the IDG, is responsible for certifying and recertifying that a patient is terminally ill. The medical director, or the physician member of the IDG, is also required to actively work with the IDG to establish patient specific plans of care and to routinely review and update those plans of care to assure that the patient/family continues to receive needed care and services.

When a patient does not have an attending physician, the medical director can fill that role. The relationship between the medical director and the attending physician should be a collaborative one where the two work together to assure that the patient is receiving care that meets his/her needs and is reflective of the hospice philosophy.

The outcome oriented survey process will focus first on assuring that the hospice has an individual committed to serve as its medical director and that this individual assumes overall responsibility for the medical needs of the

patient. If the medical director is not assuming the overall responsibility for the medical component of the hospice's patient care program, then the hospice is not in compliance with the conditions at 42 CFR 418.54.

(4) Continuous Home Care:

Continuous home care can be provided when a patient enters into a period of crisis and requires continuous care to achieve palliation or management of acute medical symptoms. A hospice is expected to have enough nurses on staff to handle the amount of nursing care that it believes is generally required by its patients, including continuous home care. However, a hospice may use contracted staff to supplement hospice employees in order to meet patient's needs during periods of peak patient workloads or during unusual circumstances. If a hospice who has hired enough nurses to handle the amount of nursing care that it believes is generally required by its patients, including continuous home care, experiences an unusual circumstance or a larger than usual number of patients requiring continuous home care, than it would be acceptable for the hospice to contract for additional nursing care to supplement hospice employees. We would not expect a hospice to contract for any particular type of nursing services on an ongoing, routine basis.

(5) Bereavement Counseling:

Hospices participating in the Medicare program are required to be primarily engaged in providing the care and services described in 42 CFR 418.202 and must provide bereavement counseling. Because bereavement counseling is a core service it must be provided by the hospice directly.

The regulations at 42 CFR 418.88 require a hospice to have an organized program for the provision of bereavement services under the supervision of a qualified professional. The plan of care for those services should reflect family needs as well as a clear delineation of services to be provided and the frequency of the service delivery (up to one year following the death of the patient).

(6) Medical Supplies:

Medical supplies and appliances, including drugs and biologicals, must be provided as needed for the palliation and management of the terminal illness. When drugs and biologicals are furnished to a patient, on an outpatient basis, in accordance with his/her plan of care, the hospice may charge the patient a coinsurance amount for each palliative drug and biological prescription *furnished* by the hospice. It should be noted that only the hospice (not, for example, a pharmacy) can charge a coinsurance amount. The amount of the coinsurance for each prescription is equal to 5% of the reasonable cost of the drug or biological to the hospice determined in accordance with the drug copayment schedule established by the hospice, but may not be more than $5.00 for each prescription. If a hospice chooses to charge a coinsurance amount, its copayment schedule must be reviewed for reasonableness and approved by the intermediary before it is used.

(7) Clinical Records:

All hospices must establish and maintain a clinical record for every individual receiving care and services. Each clinical record must be a comprehensive compilation of information with entries made for all services provided, including those provided under arrangements made by the hospice, and include any evaluations, treatments, and progress notes. These medical records must be readily accessible and organized in way that will facilitate retrieval. Additionally, if a hospice operates at multiple locations, all hospice patients' clinical records requested by the surveyor must be readily available at the hospice site issued the provider number during the time that the surveyor has allotted for the record review portion of the survey.

A patient's clinical record must be sufficient to support Medicare payment determination. This means specifically that the clinical record must contain documentation to support the medical prognosis of terminal illness.

(8) Inpatient Care:

If short-term inpatient care is necessary for a hospice patient the hospice ensures that the inpatient care is furnished only in a facility which meets the requirements in 42 CFR 418.98 and its arrangement for inpatient care is described in a legally binding written agreement that meets the requirements of 42 CFR 418.56(b) and that also specifies at a minimum-

(1) That the hospice furnishes to the inpatient provider a copy of the patient's plan of care and specifies the inpatient services to be furnished;
(2) That the inpatient provider has established policies consistent with those of the hospice and agrees to abide by the patient care protocols established by the hospice for its patients;
(3) That the medical record includes a record of all inpatient services and events and that a copy of the discharge summary and, if requested, a copy of the medical record are provided to the hospice;
(4) The party responsible for the implementation of the provisions of the agreement; and
(5) That the hospice retains responsibility for appropriate hospice care training of the personnel who provide the care under the agreement.

It is the responsibility of the hospice to establish a cooperative arrangement with the provider of inpatient care to assure that the patient's plan of care can be developed, with the consent of the patient, in a manner that is consistent with the requirements governing both the hospice and the inpatient provider.

(9) Hospice – Multiple Locations:

Neither the statute nor the hospice regulations provides for establishing hospice "satellite" offices. Nonetheless, a hospice is not precluded from providing services at more than one location if certain requirements assuring quality of care are met and these locations are approved by the HCFA regional office (RO). The RO will make a final determination on quality issues with the assistance of the State agency and the fiscal intermediary, if necessary, and will notify all parties of its decision.

To support our concern for quality, we require a hospice who provides services at more than one location, to comply with the following:

- Each location must be reported to the RO at the time of the hospice's entry into the Medicare program, or, if established subsequent to the entry, must be proposed to the RO for approval before hospice services are provided.

- Each location must provide the same full range of services that is required of the hospice issued the provider number.

- Each location must be responsible to the same governing body and central administration that governs the hospice issued the provider number, and the governing body and central administration must be able to adequately manage the location and assure quality of care at the location. For example, the hospice must be able to exert the supervision and control necessary at each location to assure that all hospice care and services continue to be responsive to the needs of the patient/family at all times and in all settings.

- All hospice patients' clinical records requested by the surveyor must be readily available at the hospice site issued the provider number. (See section on clinical records)

If a proposed hospice location does not meet the above criteria, it must seek Medicare approval as a separate hospice with its own provider agreement and provider number.

If the hospice does operate at multiple locations, a deficiency found at any location will result in a compliance issue for the entire hospice.

(10) Hospice/Home Health Agencies:

Many entities have found it advantageous to be dually certified to provide both Medicare hospice and home health services. Some of these dually certified providers have created "pre-hospice" programs for terminally ill individuals who either do not meet the Medicare hospice eligibility requirements or choose not to elect the hospice benefit. When possible attempt to coordinate simultaneous surveys of a dually certified hospice/HHA and be aware of the following:

- A terminally ill patient who does not wish to elect the Medicare hospice benefit, and who meets the eligibility criteria for skilled care under the Medicare home health benefit is eligible to receive home health care under a plan of care established by the patient's physician and the HHA. If the HHA is a part of a larger organization that is also approved as a hospice, the HHA may choose, in the interest of the terminally ill patient, to coordinate his/her care with the hospice staff, and contract with the hospice staff to provide care to the patient. This is especially true if the physician's plan of care reflects the hospice philosophy and it is expected that the patient will eventually elect the hospice benefit.

- If the terminally ill patient does not meet the admission criteria for the Medicare home health benefit, the home health services would not be reimbursed under Medicare.

- The hospice must meet the hospice CoPs, be certified, and bill under its own provider number. The HHA must meet the HHA CoPs, be certified, and bill under its HHA. The hospice cannot bill under the home health agency provider number and vice versa. Also, the hospice may not bill Medicare for home health services unless the hospice is also certified as an HHA and is billing Medicare under its HHA provider number. Medicare does not recognize "pre-hospice" programs as separate providers with distinct provider numbers or provisions for payments as such under the law.

- The HHA CoPs (conditions) are applicable to terminally ill patients of the HHA, since the conditions apply to all patients of the HHA regardless of diagnosis. Therefore, the HHA, in accordance with 42 CFR 484.10, has a responsibility to clearly inform the patient of his/her rights to Federal services and to protect and promote the exercise of these rights. This responsibility includes an explanation of the care to be furnished and any changes in that care. If the entity is approved for Medicare as both an HHA and a hospice, the explanation should include the difference between the two benefits and the Federal payment(s) that may be expected from either or both.

- Terminally ill patients who are admitted by the HHA for skilled services are considered HHA patients. These patients may be selected for the clinical record review and home visit during the HHA certification survey.

- Despite the coordination done by the hospice/HHA entities, it is reasonable to expect that the operations will be absolutely distinguishable for survey purposes and also that the patients and their families will be able to know the difference and can explain it if one of them is the subject of a home visit or phone call. For example, it is expected that there is a clear distinction in terms of medical records and organizational structure between the hospice and the HHA.

We hope that this information will help to answer questions and concerns that may arise during Medicare hospice surveys in your region. Please feel free to contact Carol Blackford, at (410) 786-5909 with any coverage or eligibility concerns or Mavis Connolly, at (410) 786-6707 with any survey and certification concerns.

/s/ Thomas Hoyer, Director
Office of Chronic Care & Insurance Policy, BPD

/s/ Robert Streimer, Deputy Director
Health Standards and Quality Bureau